UNIVERSITY OF WASHINGTON
INTERNATIONAL CLINICAL RESEARCH CENTER

DECOLONIZING GLOBAL HEALTH TOOLKIT

Last Revised: March 2021

Acknowledgements

This document was created by a decolonizing global health working group (est. July 2020) at the International Clinical Research Center (ICRC) comprised of faculty, staff, and students. The ICRC decolonizing global health workgroup members include, Jared Baeten, Ruanne Barnabas, Elizabeth Bukusi, Michelle Bulterys, Connie Celum, Jade Fairbanks, Sean Galagan, Renee Heffron, Kate Heller, Meighan Krows, Nelly Mugo, Katrina Ortblad, Caitlin Scoville, Adrienne Shapiro, Jenell Stewart, Kathy Thomas, and Jennifer Velloza. As a group, we recognize that this toolkit is only a starting point, but we hope that other groups find it helpful and are able to adopt it to their current and upcoming international collaborations. All feedback and suggestions are welcome as we continue to develop this toolkit; please feel free to contact Jenell Stewart at jenells@uw.edu.

Decolonizing: the act of becoming free from colonial status.
Decolonizing Global Health: reversing the legacy of colonialism in health equity work.

Introduction

The primary aims of decolonizing global health practices are to 1) achieve equitable collaborations, 2) center projects around local priorities, 3) diversify leadership, and 4) promote respectful, collaborative interactions and language/tone in all communications. We focus here on self-reflection and discussions on actions and language of investigators in positions of power, typically investigators from the global North working in the global South but also applies to local investigators with higher status in their own communities, and we aim to address the legacy of colonialism in collaborative environments both internally and bidirectionally. Decolonization of current practices in academic institutions, with a focus on research taking place at international sites and global health projects, is:

- first about acknowledging the historical role of colonialization in the establishment of medical training, research, and aid projects and
- second, identifying the colonizing roles we ourselves have taken and are continuing to take in our medical training, research, and aid projects and
- third, dismantling structures and power dynamics that uphold that colonial legacy both internationally and locally.

Racism, anti-Blackness, anti-indigenous, and tribalism are intimately intertwined with colonialism. In many instances, racism was used as a malicious justification for colonialism and enslavement, and tribalism was deeply exacerbated or manufactured by colonizers with unique challenges in each context. Importantly, we continue to uphold the colonial legacy in our work environments through hiring practices, team structures/hierarchies, and implementation of projects. Significant work is needed to address racism and tribalism within local and international teams, and this toolkit focuses on the international collaboration component. This

toolkit does not include essential resources for context specific tools needed to address racism, anti-Blackness, anti-indigenous, and tribalism. We strongly recommend that teams use this toolkit in conjunction with other resources needed to address these key issues. We are engaging in the important but challenging work of attempting to consciously disassemble the structures we are working in, ensuring buy-in for this effort while we continue to work within that structure as it is being segmented to its basic components and then attempting to redesign and rebuild it. This will be an uncomfortable process, but it is out of discomfort that we are the most motivated to change. The discomfort we take on as part of this work is small, compared to the levels of discomfort we may alleviate for those with whom we work.

This Decolonizing Global Health Toolkit has been designed for:

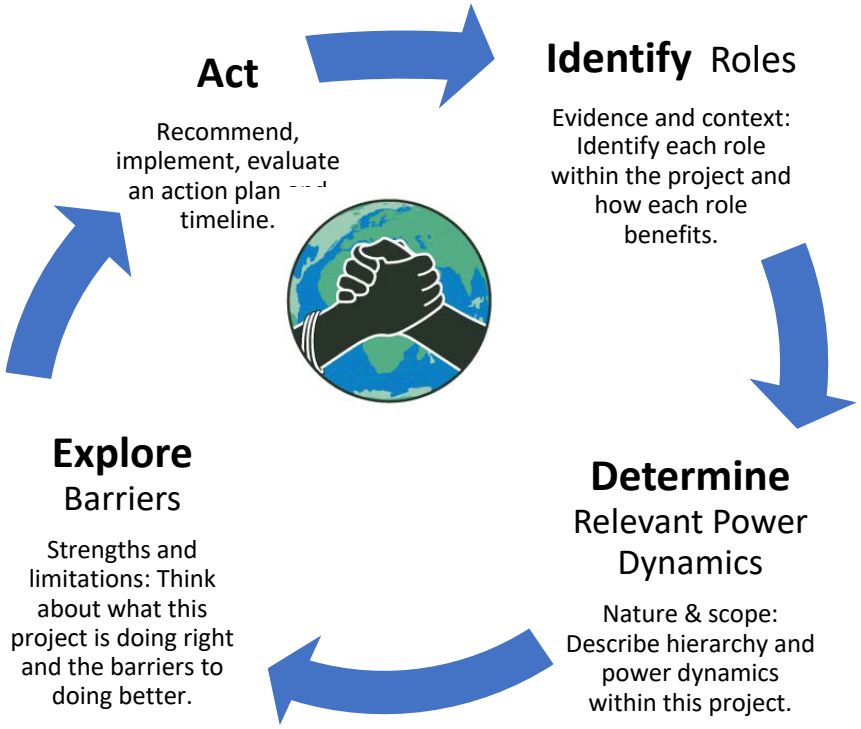
- researchers and grant writers to use at an individual level to think through plans for a project or new study,
- multidisciplinary teams to guide conversations and provide structure for discussing this complex topic and holding each other accountable, and
- organizations to evaluate how they are structured and identify areas that could be contributing to ongoing colonial power dynamics.

Drawing from literature on power dynamics in relationships and Freire's (1968) Pedagogy of the Oppressed, primary areas of focus were identified. Content was then organized into a guided tool based on the Racial Equity Tools, Brocher Declaration, and IDEA (Identify, Determine, Explore, Act) ethical framework. Paolo Freire famously wrote about the way forward in post-colonial education systems while acknowledging the complex relationship between the oppressor and the oppressed and warns of the danger of oppressors upholding colonial power structures by allowing the oppressed to be helped.

> *Any attempt to "soften" the power of the oppressor in deference to the weakness of the oppressed almost always manifests itself in the form of false generosity; indeed, the attempt never goes beyond this. In order to have the continued opportunity to express their "generosity," the oppressors must perpetrate injustice as well. An unjust social order is the permanent fount of this "generosity," which is nourished by death, despair, and poverty. That is why the dispensers of false generosity become desperate at the slightest threat to its source. True generosity consists precisely in fighting to destroy the causes which nourish false charity.*

If you find yourself hoping to avoid changes and trying to keep things the way they are, it is especially important to examine what it is about change that threatens you. To help you and your team think through and evaluate your project and organization, please work through the following framework of questions to identify colonial power structures that are present and how you might dismantle them. In addition to the Colonial Power Structure Assessment Framework for assistance decolonizing at a project level, the Decolonizing Global Health Terminology Guidelines provides practical advice for communications (e.g., email, grants, manuscripts, etc.) for assistance with day to day decolonization of language.

Decolonization Power Structure Assessment – Framework



Decolonization Power Structure Assessment – Discussion Guide

1. <u>Identify the Roles</u>
    a. Evidence and context: Identify each role within the project and how each role benefits.
    b. **ASK:**
        i. Who (individuals or groups) is directly and indirectly involved in this project?
        ii. In what way does each person or group benefit from this project? Take additional time to reflect on how you personally benefit?
        iii. Who will this project have a lasting impact on?
        iv. Consider what skills (e.g. lived experience) we might be missing before, during, and after we engage in our work.

2. <u>Determine the relevant power dynamics</u>
    a. Nature & scope: Describe hierarchy and power dynamics within this project.
    b. ASK:
        i. Does the structure of the project provide equitable opportunity for promotion and/or lasting impact?

ii. In design of this project, whose perspectives were sought (e.g. colleagues, study staff, CAB, potential research participants)?
iii. Who holds leadership positions and who holds the power to make decisions about the project? Consider whether the power is held in theory or in practice.
iv. Thinking about each role and individual, do individuals with more/most immediate knowledge hold power to act and make decisions about the project?
v. Thinking about each role and person, what amount of time would be needed to train someone to fill each role (years, months, weeks, or days)?
vi. Thinking about each role and individual, identify how many communication steps each person is removed from being able to directly communicate with the funders?
vii. What is the author order on the paper? What is the editing process for grants? E.g. review committees and potential reconfiguration of editorial review boards.
viii. Are we writing about the research to center around local perspective or the 'foreign gaze'?

3. <u>Explore the Barriers</u>
    a. Strengths and limitations: Think about what this project is doing right and the barriers to doing better.
    b. **ASK:**
        i. What are the barriers to funders and PIs giving equal power to all study roles (differences in access to promotion, lasting impact, a larger role)?
        ii. Consider the role that implicit bias may contribute to who gains trust and power in their project role and how quickly?
        iii. What are the barriers to equitable budget management?
        iv. What are the barriers to equitable data management, reporting, and analysis?
        v. What are the barriers to equitable operations management?
        vi. What are the barriers to equitable training opportunities and funding protected time to leverage capacity (i.e., training workshops)?
        vii. What are the barriers to improving authorship and inclusion?

4. <u>Act</u>
    a. Recommend, implement, evaluate an action plan and timeline.
    b. **ASK:**
        i. Are we (am I) comfortable with the current structure and power dynamics of this project?
        ii. Might our structures and power dynamics be modified with actionable changes and training?
        iii. What are ways in which we can hold ourselves accountable for questioning these power dynamics and exploring solutions?
        iv. Think about each of the barriers identified; can they be addressed now, later, or in future projects?
        v. What are ways in which we can monitor and evaluate the goals in this framework?
        vi. Who is responsible for measuring these outcomes and how often?

Decolonization Power Structure Assessment – Worksheet

Power Structure Assessment	I - Identify D - Determine E - Explore A - Act

Date	
Study/Project	
Team	
Contact Person	

Identify the Roles

Evidence and context: List out all team roles and key stakeholders	Identify how each role benefits in the short and long term.

Determine the Relevant Power Dynamics

Nature and scope: describe the hierarchy within this project	Describe power dynamics within this project (decision making, perspective, gaze, etc).

Explore the Barriers	
What areas of this project lack equity?	What are the barriers to changing these?

Act	
Recommended action items	Timeline (immediate, soon, or next project)

APPENDIX A. ICRC TERMINOLOGY GUIDELINES

These terminology guidelines are adapted from the Joint United Nations Programme on HIV/AIDS (UNAIDS) terminology guidelines last revised in 2015 as well as the 2020 PATH article by David Verga, How we talk about public health and why it matters. The ICRC terminology guidelines are meant to evolve as the center works to make progress on decolonizing global health. We strongly encourage teams working in multiple countries and cultures discuss and agree upon preferred language, and blank spaces are included on this table for teams to include additional preferred terminology. To build on a discussion of preferred terms, we also recommend doing a short microaggression training/discussion focused on how the team would like to handle and discuss microaggressions, e.g., in real time, among peers, anonymous reporting, designated manager, etc. This is not an exhaustive list of terms which have or can be used to oppress participants and/or collaborators. In addition to terminology, careful attention is needed to avoid patronizing tone even with the most carefully selected terms, e.g. "quality control queries" is an acceptable research term but can be used in an oppressive manner.

PREFERRED TERMINOLOGY

Do not use	Background	Preferred Term
HIV-infected; AIDS-infected/AIDS carrier; transmitters; PLHIV	• No one is infected with AIDS • AIDS carrier or transmitter is incorrect, stigmatizing and offensive • People should not be referred to as an abbreviation (e.g. PLHIV). This is dehumanizing.	Person living with HIV; HIV positive
AIDS virus; HIV virus	• AIDS is a clinical syndrome, not a virus • Virus is redundant in HIV	HIV
Beneficiary	• Patronizing loss of agency or independence	People, communities, countries, clients, partners, or end users.

	• Lacks context as to why the inequity or disparity in question exists in the first place	
Church; synagogue; mosque; religious organization	• Faith-based organization is more inclusive and moves away from more typically Western patterns of thought	Faith-based organization
Commercial sex work; commercial sex worker; prostitute	• 'Commercial' and 'work' are redundant • Sex worker is intended to be non-judgmental and focuses on the working conditions under which sexual services are sold • Children cannot be involved in sex work. They are considered to be victims of sexual exploitation.	Sex work, commercial sex; sex worker, person who sells sex
Developing Countries	• Implies that it is incomplete	Low- and middle-income countries, low resourse settings
Disabilities	• An umbrella term for people who have physical, mental, intellectual, or sensory impairments that may hinder their full & effective participation in society • Emphasize the person	Persons or people with disabilities
Drug addict; drug abuser; intravenous drug user	• These terms are derogatory • People should never be referred to has an abbreviation (e.g. IDU). This is dehumanizing. • Emphasize the person	Persons or people who inject drugs; person who uses drugs
Empower	• Empowerment is something that occurs across groups and within shared structures. Power cannot be given unless power is absolutely controlled.	Equip, inform, educate, train
Evidence-based	• Evidence usually refers to data published in peer-reviewed journals. • Evidence-informed recognizes that	Evidence-informed

	several elements may impact decision-making, e.g. scientific evidence in addition to cultural appropriateness, concerns about equity, feasibility, etc.	
Hotspots	• Hotspot may be seen as having a negative connotation for the people within the hotspot. • It is better to describe the actual situation you are trying to convey	Use location or local epidemic and describe the situation or context
High(er)-risk group; vulnerable group	• Person first language is always preferred. • Membership within a group does not place individuals at risk, behavior does. • May create a false sense of security among people that do not identify with such groups • Increases stigma and discrimination among such groups	Key populations; [specific population] at high-risk of [outcome].
In the field	• Paints a picture that you're working on a dirt road, not in classrooms, offices and labs	Office, lab, clinic, classroom, etc. in X country/location
Intervention	• This term means different things in different contexts. • When describing programs at the community level, its use can convey doing something to someone and undermines the concept of participatory practice.	Programming, program, activities, initiatives, etc.
Most at risk populations (MARPs)	• Stigmatizing • People should never be referred to as an abbreviation	Describe the behavior each population is engaged in that puts an individual at risk (e.g. unprotected sex among serodiscordant couples, sex work with low condom use, etc.)
Needle-syringe sharing	• It is preferable to emphasize the	Use of non-sterile injecting equipment or

	availability of injecting equipment rather than the behavior of individuals when injecting equipment is in short supply	multi-person use of injecting equipment
Risk of AIDS	• Do not use unless referring to behaviors or conditions that increase the risk of disease progression in an HIV-positive person	Risk of acquiring HIV; risk of exposure to HIV
Safe sex	• Safer sex reflects the idea that choices can be made/behaviors adopted that reduce the risk of HIV acquisition.	Safer sex
Target	• Avoid using as a verb. This conveys non-participatory, top-down approaches.	Engage; involve; focus; designed for and by
Target populations	• It is better to refer to populations that are key to the epidemic and key to the response	Priority populations; key populations
Sexually transmitted disease (STD); venereal disease (VD)	• Many sexually transmitted infections (STIs) do not cause symptoms and are not recognized by infected individuals as diseases	Sexually transmitted infections (STIs)
Vulnerable	• Disrespectful and over-generalizes • Suggests personal weakness or helplessness	Marginalized by X, At risk of X
	•	
	•	
	•	

APPENDIX B. MICROAGGRESSIONS DISCUSSION GUIDE FOR TEAMS

To value and honor diverse experiences and perspectives, we must strive to create welcoming and respectful working environments. Unfortunately, microaggressions are a persistent negative force which require active strategies for countering. The experience of microaggressions can lead to poorer mental health (depression, anxiety, suicidal ideation, drug/alcohol abuse, etc.), and it is everyone's responsibility to respond to and stop microaggressions.

This discussion guide aims to create and protect a climate of inclusion by identifying and addressing microaggressions.
**adapted from materials by Dr. Blain for the UW Infectious Diseases clinical consult service.*

IDENTIFYING MICROAGRESSSIONS

- **Microaggressions** – "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults towards people of color."[1]
    - Also applies to other marginalized groups – women, people with disabilities, sexual and gender minorities, religious minorities, body type/weight, etc.[2]
    - Common categories and examples of microaggressions are listed in Table 1.[3]

Table 1. Common categories and examples of microaggressions		
Type of microaggression	Explanation	Examples
Ascription of intelligence	e.g. unintelligent or smarter than average based on appearance or accent	"*Your English is so good," "You are so articulate," "B is an Asian Fail"*
Denial of racial reality (microinvalidations)	e.g. dismissing claims that race was relevant to understanding a colleague's experience	"*This has nothing to do with race," "It's ok to touch your hair because I have curly hair too,"*
Denial or devaluing of experience or culture	e.g. ignoring the existence, histories, cultures of groups of people – assuming that others are like you	*Mistaken identity of people from the same racial/ethnic group ("All Asians look alike"), or dismissing group identities ("I don't understand why non-transgender people have to use pronouns")*
Making judgments about belonging	e.g. assuming people are foreign or don't speak English well because of their appearance; questioning someone's membership status such as "	"*You don't look disabled" or "you don't seem that gay to me" or "if you were Jewish, wouldn't you do x?"*
Assumption of criminality	e.g. guarding belongings more carefully when around certain groups or expressing fear of certain groups	"*Watch out in that neighborhood there are a lot of mosques there."*

Assumption of immorality	e.g. assuming that poor people, undereducated people, LGBTQ people, or people of color are more likely to be devious, untrustworthy, or unethical	*Judging participants for difficulties with accessing care, rather than recognizing barriers ("non-compliant", "failed")*
Making judgements on body image	e.g. making comments on people's body weight, figure, or appearance. These judgements can be stigmatizing and triggering.	*"You lost so much weight! You look healthier!" "You're so skinny, you need to eat more!"*

ADDRESSING MICROAGGRESSIONS

- **Start the dialogue early with your team - key talking points:**
  - People will say things that are demeaning based on a person's race, gender, sexual orientation, or appearance and may not realize they are doing it.
  - In an inclusive workplace and collaboration, it is everyone's responsibility to raise awareness by calling out microaggressions – preferably either in the moment or immediately after the interaction has ended.
  - How would people like to address microaggressions (i.e. some may want to discuss the issue with a supervisor while others may want to speak for themselves) and how they would like to receive feedback about their own microaggressions?
  - Team leaders should layout their approach microaggressions that are brought to their attention. What is your initial approach plan? What is your follow up plan?

Table 2. Reflecting in Action

Principle	Example
Question the comment and its implications	*Could you explain what you meant when you said XX?*
Address the comment: name the behavior as inappropriate	*I'm surprised you thought that would be an appropriate comment/joke* *I'm so glad you like my idea!* (when someone interrupts or steals an idea of another team member)
Refocus the conversation	*We are here to focus on…*
Share your perspective	*I think you're trying to complement me, but I heard XX.* *When you said XX, I felt YY.*

Example strategies for dealing with microaggressions in your team are described in Table 2.[4]

References & Resources:

1. Sue DW, Capodilupo CM, Torino GC, et al. Racial microaggressions in everyday life: implications for clinical practice. Am Psychol. 2007May-Jun;62(4):271-286.
2. Overland MK, Zumsteg JM, Lindo EG, et al. Microaggression in Clinical Training and Practice. PM&R. 2019 Sep;11(9):1004-1012.
3. https://www.washington.edu/teaching/addressing-microaggressions-in-the-classroom/
4. Shankar M, Albert T, Yee N, Overland M. Approaches for Residents to Address Problematic Patient Behvior: Before, During, and After the Clinical Encounter. J Grad Med Educ. 2019 Aug;11(4):371-374.